

LICENSEE EVENT REPORT (LER)

FACILITY NAME (1) THREE MILE ISLAND, UNIT 1	DOCKET NUMBER (2) 0 5 0 0 0 2 8 9 1	PAGE (3) 1 OF 0 3
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TITLE (4)  
MISSED SAMPLE PRIOR TO AN INDUSTRIAL WASTE FILTER SYSTEM RELEASE

EVENT DATE (5)			LER NUMBER (6)			REPORT DATE (7)			OTHER FACILITIES INVOLVED (8)		
MONTH	DAY	YEAR	YEAR	SEQUENTIAL NUMBER	REVISION NUMBER	MONTH	DAY	YEAR	FACILITY NAMES		DOCKET NUMBER(S)
0 5	0 6	8 7	8 7	0 0 5	0 0 0	0 6	0 3	8 7			0 5 0 0 0
											0 5 0 0 0

THIS REPORT IS SUBMITTED PURSUANT TO THE REQUIREMENTS OF 10 CFR § (Check one or more of the following) (11)

OPERATING MODE (9)  POWER LEVEL (10) 1 0 0	<input type="checkbox"/> 20.402(b)	<input type="checkbox"/> 20.408(e)	<input type="checkbox"/> 60.73(a)(2)(iv)	<input type="checkbox"/> 73.71(b)
	<input type="checkbox"/> 20.408(a)(1)(i)	<input type="checkbox"/> 60.38(e)(1)	<input type="checkbox"/> 60.73(a)(2)(v)	<input type="checkbox"/> 73.71(c)
	<input type="checkbox"/> 20.408(a)(1)(ii)	<input type="checkbox"/> 60.38(e)(2)	<input type="checkbox"/> 60.73(a)(2)(vi)	OTHER (Specify in Abstract below as in Text, NRC Form 365A)
	<input type="checkbox"/> 20.408(a)(1)(iii)	<input checked="" type="checkbox"/> 60.73(a)(2)(i)	<input type="checkbox"/> 60.73(a)(2)(vii)(A)	
	<input type="checkbox"/> 20.408(a)(1)(iv)	<input type="checkbox"/> 60.73(a)(2)(ii)	<input type="checkbox"/> 60.73(a)(2)(vii)(B)	
	<input type="checkbox"/> 20.408(a)(1)(v)	<input type="checkbox"/> 60.73(a)(2)(iii)	<input type="checkbox"/> 60.73(a)(2)(viii)	
<input type="checkbox"/> 20.408(a)(1)(vi)	<input type="checkbox"/> 60.73(a)(2)(iv)	<input type="checkbox"/> 60.73(a)(2)(ix)		

LICENSEE CONTACT FOR THIS LER (12)

NAME DENNIS V. HASSLER, TMI-1 LICENSING ENGINEER	TELEPHONE NUMBER AREA CODE: 7 1 7 7 4 8 - 8 8 3 3
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COMPLETE ONE LINE FOR EACH COMPONENT FAILURE DESCRIBED IN THIS REPORT (13)

CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS	CAUSE	SYSTEM	COMPONENT	MANUFACTURER	REPORTABLE TO NPROS

SUPPLEMENTAL REPORT EXPECTED (14)

YES (If yes, complete EXPECTED SUBMISSION DATE)	<input checked="" type="checkbox"/> NO	EXPECTED SUBMISSION DATE (15)	MONTH	DAY	YEAR

ABSTRACT (Limit to 1400 spaces, i.e., approximately fifteen single-space typewritten lines) (16)

On May 5, 1987, the plant was at 100% reactor power. In order to support corrective maintenance the radiation monitoring liquid effluent instrumentation (RM-L-12) was in bypass (automatic interlock in defeat) such that high radiation levels in the effluent would not be terminated automatically. A release of the Industrial Waste Treatment System was in progress.

With RM-L-12 in bypass, activity samples for the Waste Treatment System release were being taken every 8 hours in accordance with Tech. Spec. requirements. On May 6, 1987 an Industrial Waste Filter System release was initiated. With RM-L-12 in bypass (recorder out of service), the technical specification action statement requires a grab sample with beta and gamma analysis prior to the release. This sample was not analyzed prior to the release. During the release an operator was assigned to RM-L-12 to terminate the release in the event of a high alarm on RM-L-12.

This is considered personnel error as the procedure was not followed. Operations and Chemistry personnel have been counseled to assure compliance with the procedure requirement. Since the release was monitored by an operator, there were no safety consequences or implications.

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LICENSEE EVENT REPORT (LER) TEXT CONTINUATION

FACILITY NAME (1)  THREE MILE ISLAND, UNIT 1	DOCKET NUMBER (2)  0 5 0 0 0 2 8 9 8 7 - 0 0 5 - 0 0	LER NUMBER (6)			PAGE (3)		
		YEAR	SEQUENTIAL NUMBER	REVISION NUMBER			
					0 2	OF	0 3

TEXT (If more space is required, use additional NRC Form 386A's) (17)

I. Plant Operating Conditions Before the Event

The plant was operating at 100% reactor power. There were no abnormal conditions or equipment lineups.

II. Status of Structures, Components, or Systems that Were Inoperable at the Start of the Event and that Contributed to the Event

The radiation monitoring liquid effluent instrumentation (RM-L-12)(IL/RI)\* was in bypass (automatic interlock in defeat) such that high radiation levels in the effluent would not be terminated automatically. An auxiliary operator was available monitoring the digital meter on RM-L-12. A release of the IWTS (Industrial Waste Treatment System) (WH/-)\* was in progress.

III. Event Description

On May 5, 1987 at approximately 0850, an I&C technician requested that RM-L-12 be placed in bypass to work on the chart recorder (IL/RR)\*. The recorder was O.O.S. (out of service) due to reading slightly higher than the digital ratemeter (IL/RR)\*. The control room requested activity samples of the IWTS release every 8 hours in accordance with technical specifications. At 1500 the same day, the I&C technician completed work with RM-L-12 in "bypass." The 3-11 and 11-7 (shifts) auxiliary operators were dedicated to this release maintaining an hourly log of RM-L-12 digital ratemeter and recorder counts. They knew to terminate the release and notify the control room in the event the radiation monitor increased to the high alarm setting of 940 cpm (release remained <250 cpm).

The next morning (May 6, 1987) at 0605, an IWFS (Industrial Waste Filter System) (WH/-)\* release was initiated. RM-L-12 was monitoring the effluent without an automatic trip function. With RM-L-12 not available the technical specification action statement requires a grab sample with beta and gamma analysis prior to the release. The radiation monitoring capability was available functionally monitoring the release on a continuous basis. An auxiliary operator was assigned to terminate the release in the event of a high alarm. The shift supervisor at approximately 0900 this day questioned actions taken as a result of initiating the IWFS release. As a result of subsequent investigation and review, the event has been determined reportable since the IWFS sample was not analyzed prior to the release which violated the technical specification.

The root cause was personnel error in failure to follow the required procedure step which implemented the technical specification action statement.

IV. Component Failure Data

Not Applicable. No components failed for this event.

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			- 0 0 5	- 0 0	0 3	OF 0 3

TEXT (If more space is required, use additional NRC Form 366A's) (17)

V. Automatic or Manually Initiated Safety System Responses

None

VI. Assessment of the Safety Consequences and Implications of the Event

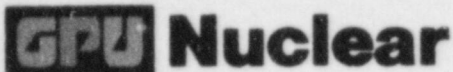
There were no safety consequences of this event nor any safety implications since the release was monitored by an auxiliary operator assigned to the radiation monitor. In the event of a high alarm, the operator would have terminated the release.

VII. Previous Events of a Similar Nature

LER 83-039 - Failure to obtain Vent Header Sample.

VIII. Corrective Action Planned

Operations and Chemistry personnel have been counseled to assure compliance with the procedure and technical specification requirements.



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June 3, 1987  
5211-87-2113

U. S. Nuclear Regulatory Commission  
Document Control Desk  
Washington, D.C. 20555

Dear Sir:

Three Mile Island Nuclear Station Unit I, (TMI-1)  
Operating License No. DPR-50  
Docket No. 50-289  
LER 87-005-00

This letter transmits Licensee Event Report (LER) No 87-005-00 which involves a Missed Sample Prior to an Industrial Waste Filter System Release. Public health and safety were unaffected.

This LER is being submitted pursuant to 10 CFR 50.73, using the required NRC forms (attached). NRC Form 366 contains an abstract which provides a brief description of the event. For a complete understanding of the event, refer to the text of the report which appears on Form 366A.

Sincerely,

*H. D. Hukill for*

H. D. Hukill  
Vice President & Director, TMI-1

HDH/DVH/spb

Attachment

cc: G. Edison  
W. Russell  
R. Conte

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